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May 22, 1981  
L-81-220

Mr. James P. O'Reilly, Director, Region II  
Office of Inspection and Enforcement  
U. S. Nuclear Regulatory Commission  
101 Marietta Street, Suite 3100  
Atlanta, Ga. 30303

Dear Mr. O'Reilly:

Re: RII:  
50-250/81-07  
50-251/81-07

Florida Power & Light Company has reviewed the subject inspection report and a response is attached.

There is no proprietary information in the report.

Very truly yours,

Robert E. Uhrig  
Vice President  
Advanced System and Technology

REU/JEM/ras

Attachment

cc: Harold F. Reis, Esquire

8106100221



ATTACHMENT

Re: Turkey Point Units 3 and 4  
Docket Nos. 50-250, 50-251  
IE Inspection Report 81-07

FINDING A

Technical Specification 6.8.1 requires written procedures and administrative policies be established, implemented, and maintained that meet the requirements and recommendations of Section 5.1 and 5.3 of ANSI 18.7 - 1972 and Appendix "A" of Regulatory Guide 1.33. Operating Procedure 5120, Waste Disposal System - Laundry and Hot Shower System - Normal Operation, did not specify waste water transfer to CVCS Monitor Tank A.

Contrary to the above, on March 10, 1981, Operating Procedure 5120 was not followed in that laundry waste water was inadvertently transferred to CVCS Monitor Tank A which subsequently overflowed.

RESPONSE A

- (A-1) FPL concurs with this finding.
- (A-2) The reason for the finding is that Operating Procedure 5120 inadvertently neglected this operating evolution.
- (A-3) As corrective action, Operating Procedure 5120 was revised to include provisions for the transfer of fluid to the CVCS Monitor Tank A from the laundry tank. These revisions were implemented on March 24, 1981.
- (A-4) As corrective action to avoid further problems, Operating Procedure 5120 will be followed for transfers of liquid from the laundry tank to other tanks.
- (A-5) Full compliance was achieved on March 24, 1981.



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
101 MARIETTA ST., N.W., SUITE 3100  
ATLANTA, GEORGIA 30303

APR 3 0 1981

Florida Power and Light Company  
ATTN: R. E. Uhrig, Vice President  
Advanced Systems and Technology  
P. O. Box 529100  
Miami, FL 33152.

Gentlemen:

Subject: Report Nos. 50-250/81-07 and 50-251/81-07

This refers to the routine inspection conducted by A. J. Ignatonis of this office on February 26 - March 25, 1981, of activities authorized by NRC Operating License Nos. DPR-31 and DPR-41 for the Turkey Point facility. Our preliminary findings were discussed with J. K. Hays at the conclusion of the inspection.

Areas examined during the inspection and our findings are discussed in the enclosed inspection report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observations by the inspectors.

During the inspection, it was found that certain activities under your license appear to violate NRC requirements. This item and references to pertinent requirements are listed in the Notice of Violation enclosed herewith as Appendix A. Elements to be included in your response are delineated in Appendix A.

We have examined actions you have taken with regard to previously identified enforcement matters. These are discussed in the enclosed inspection report.

In accordance with Section 2.790 of the NRC "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and the enclosed inspection report will be placed in the NRC Public Document Room. If this report contains any information that you believe to be proprietary, it is necessary that you make a written application within 20 days to this office to withhold such information from public disclosure. Any such application must include the basis for claiming that the information is proprietary and the proprietary information should be contained in a separate part of the document. If we do not hear from you in this regard within the specified period, the report will be placed in the Public Document Room.



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APR 3 0 1981

Florida Power and Light Company

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Should you have any questions concerning this letter, we will be glad to discuss them with you.

Sincerely,

*R. C. Lewis*  
R. C. Lewis, Acting Director  
Division of Resident and  
Reactor Project Inspection

Enclosures:

1. Appendix A, Notice of Violation
2. Inspection Report Nos. 50-250/81-07  
and 50-251/81-07

cc w/encl:

H. E. Yaeger, Plant Manager



APPENDIX A

NOTICE OF VIOLATION

Florida Power and Light  
Turkey Point 3 and 4

Docket Nos. 50-250 & 50-251  
License Nos. DPR-31 & DPR-41

As a result of the inspection conducted on February 26 - March 25, 1981, and in accordance with the Interim Enforcement Policy, 45 FR 66754 (October 7, 1980), the following violation was identified.

Technical Specification 6.8.1 requires written procedures and administrative policies be established, implemented, and maintained that meet the requirements and recommendations of Section 5.1 and 5.3 of ANSI 18.7-1972 and Appendix "A" of Regulatory Guide 1.33. Operating Procedure 5120, Waste Disposal System - Laundry and Hot Shower System - Normal Operation did not specify waste water transfer to CVCS Monitor Tank A.

Contrary to the above, on March 10, 1981 operating procedure 5120 was not followed in that laundry waste water was inadvertently transferred to CVCS Monitor Tank A which subsequently overflowed.

This is a Severity Level V Violation (Supplement I.E.).

Pursuant to the provisions of 10 CFR 2.201, you are hereby required to submit to this office within twenty-five days of the date of this Notice, a written statement or explanation in reply, including: (1) admission or denial of the alleged violation; (2) the reasons for the violation if admitted; (3) the corrective steps which have been taken and the results achieved; (4) corrective steps which will be taken to avoid further violations; and (5) the date when full compliance will be achieved. Under the authority of Section 182 of the Atomic Energy Act of 1954, as amended, this response shall be submitted under oath or affirmation.

Date: APR 3 0 1981







UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
101 MARIETTA ST., N.W., SUITE 3100  
ATLANTA, GEORGIA 30303

Docket Nos. 50-250/81-07 and 50-251/81-07

Licensee: Florida Power and Light Company  
9250 West Flagler Street  
Miami, FL 33101

Facility Name: Turkey Point

Docket Nos. 50-250 and 50-251

License Nos. DPR-31 and DPR-41

Inspection at Turkey Point site near Homestead, Florida

Inspectors: MB Shepley for  
A. J. Ignatoni

4/22/81  
Date Signed

MB Shepley for  
W. C. Marsh

4/22/81  
Date Signed

Approved by: H. C. Dance  
H. Dance, Section Chief, RRPI Branch

4/22/81  
Date Signed

#### SUMMARY

Inspection on February 26, - March 25, 1981

#### Areas Inspected

This routine inspection involved 223 resident inspector-hours on site in the areas of (1) followup of previous inspection findings; (2) followup on licensee event reports; (3) surveillance test observations; (4) followup on implementation of post-TMI requirements; (5) containment instrument relocation per IEB 79-01B; (6) plant operations; and (7) plant tours.

#### Results

Of the seven areas inspected, no violations or deviations were identified in six areas; one apparent violation was found in one area (Violation-failure to follow the Waste Disposal System Laundry and Hot Shower Drain System procedure - paragraph 9.).



## DETAILS

### 1. Persons Contacted

#### Licensee Employees

- \*H. E. Yaeger, Site Manager
- \*J. K. Hays, Plant Manager - Nuclear
- J. E. Moore, Operations Superintendent - Nuclear
- D. W. Haase, Technical Department Supervisor
- J. P. Mendieta, Maintenance Superintendent
- W. R. Williams, Assistant Superintendent Electrical Maintenance
- D. C. Bradford, Outage Management Plant Supervisor
- W. A. Klein, Licensing Engineer
- \*D. W. Jones, QC Supervisor
- C. J. Baker, Construction Coordinator
- B. A. Abrishami, Systems Test Engineer

Other licensee employees contacted included construction craftsmen, technicians, operators, security force members and office personnel.

\*Attended exit interview

### 2. Exit Interview

The inspection scope and findings were summarized on March 27, 1981 with those persons indicated in Paragraph 1 above. The site and plant managers acknowledged the stated violation.

### 3. Licensee Action on Previous Inspection Findings

(Closed) Failure to Follow Emergency Diesel Generator Normal Standby Condition Operating Procedure 4303.1 (50-250, 251/80-05-03). The inspector verified both diesel air start systems properly aligned in accordance with OP 4303.1 and a revised diagram in agreement with the procedure posted in both generator rooms. The inspector had no further questions.

### 4. Unresolved Items

Unresolved items were not identified during this inspection.

### 5. Licensee Event Report (LER) Followup

During this inspection the following Licensee Event Reports were reviewed to assure the accuracy and completeness of the report, that regulatory requirements had been met, and that appropriate corrective actions were being taken. The LER's listed below were reviewed with comments as appropriate.



### 250/80-29 "3A" Boric Acid Transfer Pump Leak Repair

The "3A" Boric Acid Transfer (BAT) pump was removed from service due to a water leak. It was repaired and then returned to service. Outages for the same type of pump on Unit 4 have been previously recorded. These pumps are the Series G chem pumps manufactured by Crane, and are of a canned pump and motor design. Due to previous history of motor problems and the unavailability of replacement motors, the licensee will replace all of the BAT pumps with Goulds pumps scheduled for installation during the summer of 1981. The Goulds pump casing will be separated from the motor.

### 250/81-02 Boric Acid Flowpath Blockage

In review of this event, the inspector noted that another similar event occurred on Unit 4 subsequent to this report. In both cases the apparent cause of obstruction in the lines resulted from failed and faulty heat tracing circuits. The licensee restored the flow by repairing the heat tracing circuit. These heat tracing circuits are of the Chromalox design, however, in the long-term the licensee has committed to replace all of the circuits with the Chemelex type which are more easily maintained and appear to be more reliable. Since an LER on Unit 4 boric acid flowpath blockage is forthcoming, LER 250-81-02 will remain open. The inspector expects to complete this evaluation in the subsequent inspection report.

## 6. Surveillance Test Observations

On March 18, 1981 the inspector witnessed testing of the 3A Intake Cooling Water System Pump following maintenance and portions of the monthly surveillance test on the Unit 4 pumps. The tests were performed in accordance with Operating Procedure 3404.2, Intake Cooling Water System - Periodic Test of Pumps. The following inspection items were verified: Testing is scheduled in accordance with technical specification requirements, procedures were being followed, testing was by qualified personnel, LCOs were being met, and system restoration was correctly accomplished following testing.

No violations or deviations were identified for the areas inspected above.

## 7. Followup on Implementation of Post-TMI Requirements

(Open). Item II.F.1, Accident Monitoring

In the monthly inspection report of October, 1980 (50-250/80-33; 50-251/80-32) pertaining to the inspector followup on the implementation of post-TMI Lessons Learned Category "A" requirements, it was stated that the wide range noble gas monitors and the high range containment radiation



monitors were scheduled to be installed in Unit 3 and 4 containments during the March-April, 1981 outage and the November, 1980 - January, 1981 outage, respectively. The status of these requirements is as follows:

For Unit 3 containment the installation of the radiation monitors will be completed during this current March-April, 1981 outage. One detector has been installed at the 58 foot level, on the steam generator 3A shield wall. Installation of the other detector is in progress which will be located on the 14 foot level next to the personnel access penetration. The associated recorders and meters that will be located in the main control room will be installed at a later date. Due to late delivery of the high range radiation monitors the installation of these detectors for Unit 4 containment will slip to the July, 1981 outage.

The wide range noble gas monitors have not been installed for either unit. One noble gas monitor unit has been recently delivered to the site. This unit has been designated to monitor the Unit 3 spent fuel pool vent stack. The others are planned to monitor effluents released from the air ejectors, the stack vent which is common to both unit containments, and main steam. The licensee is awaiting delivery for the remaining wide range noble gas monitor units. The inspector verified the installation and receipt of the hardware described above, and will continue to carry this as a followup item.

(Closed) Item II.F.2.1a., Instrumentation for Core Cooling

Also, during the current Unit 3 outage the licensee installed redundant resistance temperature detectors (RTD's) on each of the primary loop hot legs. The output of these RTD's will be fed to the sub-cooled margin meter. Originally, the sub-cooled margin monitor sensed signals from RTD's having an arrangement of one RTD located in each hot leg loop, and one RTD in each cold leg loop. This was found to be unacceptable by NRR, and as a result the configuration was modified to have two RTD's in each hot leg loop and one RTD in each cold leg loop. The sub-cooled margin meter will provide readings from the highest hot leg RTD output. The redundant hot leg RTDs and their associated wiring have already been installed for unit 4 during the November 1980 - January, 1981 outage.

8. Instrument Relocation in Containment per IE Bulletin 79-01B

In order to prevent certain safety-related electrical components from becoming submerged after a postulated event inside the containment, the licensee originally proposed to relocate and/or replace 12 components in the Unit 3 containment. These items were addressed in the component evalu-





ation section c.1 of the licensee's response to IE Bulletin 79-01B. They are as follows:

- (1) PT-3-403 Reactor coolant system (RCS) Narrow Range Pressure Transmitter
- (2) PT-3-404 RCS Pressure Transmitter
- (3) PT-3-405 RCS Pressure Transmitter
- (4) PT-3-406 RCS Pressure Transmitter
- (5) FT-3-932 Safety Injection Flow Transmitter
- (6) FT-3-933 Safety Injection Flow Transmitter
- (7) TB 3143 Terminal Box containing wiring associated with solenoid valve for CV-3-310A, Charging Pump discharge line
- (8) TB 3371 Terminal Box associated with Pressurizer Level Transmitter
- (9) TB 3379 Terminal Box associated with Steam Generator "C" Narrow Range Level Transmitter
- (10) LS-3-1570 North Containment Sump Level Switch
- (11) LS-3-1517 South Containment Sump Level Switch
- (12) SV-3-310B Solenoid Valve for CV-3-310B, Charging Line Loop "C"

On March 19, 1981 the inspector performed a walkdown in the Unit 3 containment and verified the relocation of eight instruments listed above. These were items (1) through (7) and item (12) of above. Per discussions with the licensee, PT-3-403 was not replaced as committed by the licensee. The reason is that a qualified replacement part was not available at this time; once obtained, it will be installed.

Items (8), (9), (10), and (11) of the above list were not relocated nor replaced. The list of instruments subject to potential submergence were based on Unit 4 walkdown. A similar walkdown of Unit 3 showed that items (8) and (9) do not have to be relocated since they were already above maximum flood level. Items (10) and (11) containment level switches are not planned to be relocated because they will be able to be compensated by future installation of wide range containment water level monitors required by the post-TMI lessons learned task implementation.

## 9. Plant Operations

The inspector kept informed on a daily basis of the overall plant status and any significant safety matters related to plant operations. Discussions were held with plant management and various members of the operations staff on a regular basis. Selected portions of daily operating logs and operating data sheets were reviewed on at least a weekly basis during the report period.

The inspector conducted various plant tours and made frequent visits to the control room. Observations included witnessing work activities in progress, status of operating and standby safety systems, confirming valve positions, instrument readings and recordings, annunciator alarms, housekeeping, radiation area controls, and vital area controls.

Informal discussions were held with operators and other personnel on work activities in progress and status of safety-related equipment or systems.

The inspector observed Unit 3 fuel handling operations and verified that containment integrity was maintained as required by the Technical Specifications. No violations were identified within the areas inspected.

During this reporting period the inspector followup on two occurrences described below.

On March 10, 1981 at approximately, 11:20 a.m. the contents of the laundry tanks being transferred to the Chemical Volume Control System (CVCS) 'A' monitor tank caused the tank to overflow. The over flow rate was such that the gravity drain system which transfers the overflow from the CVCS Monitor tanks to the Waste Hold-up Tank backed up and out of the floor drains in the Safety Injection Pump Room and the Unit 3 Component Cooling Pump and Heat Exchanger area. The overflow in the Safety Injection Pump Room was contained by the room structure. The overflow in the Component Cooling Pump and Heat Exchanger area which is outside the Auxiliary Building was collected by the storm drains also located in the area. The activity of the water spilled into the storm drains (which empty into the intake canal) was three to nine times less than the level authorized for release by Technical Specifications. The inspector reviewed the administrative procedure for controlling the evaluation. It was determined that the procedure had not been correctly followed in that it precludes transfer of laundry tank content to CVCS monitor Tank A. This failure to follow procedure number 5120 "Waste Disposal System - Laundry and Hot Shower Drain System - Normal Operation" constitutes a violation of technical specification 6.8 (50-250, 251/81-07-01).

On March 22, 1981, at approximately 11:30 a.m. Unit 4 tripped from 100% power on "A" steam generator low level coincident with feed flow steam flows mismatch.

The trip occurred when "A" Main Feed Regulating Valve failed shut when a protective system solenoid coil failed open, effectively producing a feed-water isolation signal for "A" Main Feed Regulatory Valve. All safety systems operated normally. The defective solenoid coil was replaced; however, the unit's return to power was delayed beyond the end of this report period due to a nonrelated problem with 4A Reactor Coolant Pump motor.

#### 10. Plant Tours

The inspector surveyed the Radiation Controlled Area excluding the interior of Units 3 and 4 containments and the spent fuel pool with the digital zetex exposure rate meter. No violations or deviations were identified within the areas inspected.

See -

